Medical Records Authorization Form

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, then the released information may no longer be protected by federal privacy regulations.

Patient Name (First & Last): ______________________________

Date of Birth (Month/Day/Year): __________________________

Email Address: ____

Telephone Number: ____________________________

Person / Organization to receive records:

- ☐ Self / Authorized Representative
- ☐ Clinic Email Address: _____________________________

Relationship to the Patient:

- ☐ Self
- ☐ Parent / Legal Guardian
- ☐ Spouse
- ☐ Other: ____________________

- ❖ All medical records to be released due to the closure of Marianas Physicians Group (SaguaMPG).
- ❖ I understand that I waive any previous "Right of Access" designations for the clinic.

Print Name: _________________________

Signature: ___________________________

Date: ____________________

Please save this document as a PDF and send to mpgpatientservices@saguampg.com .

Please allow 7 – 10 business days for processing. Note that there is a $20 processing fee.

Certain circumstances may cause delays in processing your request.

If your request is affected, our Patient Affairs team will contact you to provide assistance.

Thank you for your patience.